Alcohol Detox – A ‘cost saving’ pathway for the AECU

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Background
• Ealing Hospital has the 8th highest alcohol-related hospital admission rate in London (significantly greater than the England average) (LAPE lape.org.uk).
• It was recognised 8 years ago that there was a need for an Alcohol Service in the Emergency Department (ED)/hospital due to high numbers of alcohol related (AR) attendances and so this service was commissioned and developed.
• Alcohol withdrawal management is costly in acute hospitals and community services are unable to take on patients in a timely manner for ‘detox’.

Study Objectives
• To explore whether alcohol withdrawal management within an Ambulatory Emergency Care Unit (AECU) is safe, cost effective and prevents ED reattendance.

Methods of study

Patient selection
• ED and ward patients over the age of 16 years were selected for alcohol withdrawal management in the AECU according to criteria (as per the ‘AECU withdrawal guideline’):
  • Requirement of chlordiazepoxide to control withdrawal symptoms and signs
  • Fit free
  • No longer require in-hospital treatment for any concurrent significant physical disorder
  • Living in a supportive environment where there is adequate and suitable social support
  • Not suffering from serious physical or mental health illness which could jeopardise the safe completion of the treatment
  • Not undergone more than 1 previous ‘detox’ in the previous 12 months.

• On each attendance to the AECU, patients:
  • Underwent an alcohol breathalyser test to ensure this was negative
  • Received a daily course of take home chlordiazepoxide (from 20 mg qds to bd)
  • Engaged in ‘relapse prevention management’ delivered by the Alcohol Nurse Specialist.

Analysis methodology
• Data of attendances was reviewed retrospectively:
  • Length of stay as an in-patient prior to AECU attendance
  • No of subsequent AECU attendances
  • Subsequent ‘AR’ ED reattendance

Results
• 20 patients attended the AECU for alcohol detox in 12 months
• 17 ED patients:
  • Median length of stay (LOS) in ED (including CDU stay) = 3 hours 46 mins (graph of LOS)
  • Average no of subsequent AECU attendances = 3
  • 4 of these (23.5%) reattended the ED with an AR presentation within 12 months
• 3 ‘acute bed’ patients:
  • Average stay = 3 days prior to AECU attendance
  • Average no of subsequent AECU attendances = 3
  • 0 AR ED reattendances
• No clinical consequences in total cohort of patients
• Total no of AECU attendances = 60. Therefore potential saving of 60 bed days (60 x £305 bed day cost) and £18,300.

Conclusions
• Alcohol withdrawal is a safe and appropriate AECU pathway
• It prevents ED reattendance to the ED for AR conditions
• It is cost effective, saving bed days and reducing length of stay
• Intervention by the ANS increases engagement with community services and thus reduces the need for ED reattendance.

Future plans
• Increase the remit of patients to be seen on the AECU from the acute wards
• Patient satisfaction of this pathway should be evaluated.
• Pabrinex 2(I+II) to be given iv or im to each patient at each attendance to prevent Wernicke’s encephalopathy

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